Discounted/Sliding Fee Application

It is the policy of Improving Lives Counseling Services, Inc., to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to our office to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including referrals made to any professional outside of our agency. In the hope that your financial situation improves, discounts only apply for six months after the time of approval. This form must be completed every six months. Please inquire with our office if you have questions.

First Name: _________________Middle Name/Names:__________________Last Name:______________

DOB: _____________ Age: ________ Social Security Number:______________________Sex: ☐ M ☐ F

Address:_______________________________City:_______________State:______Zip Code:__________

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Phone Number: ____________________ Secondary Phone Number:_______________________

Place of Employment:______________________________

Household

Please list spouse and any dependents under the age of 18.

Spouse Name: Date of Birth:

Dependent Name: Date of Birth:

Dependent Name: Date of Birth:

Dependent Name: Date of Birth:

Dependent Name: Date of Birth:

Dependent Name: Date of Birth:

Dependent Name: Date of Birth:

Annual Household Income

Source	Self	Spouse	Other	Total
Gross Wages, Salaries, Tips, etc.	_______	_______	_______	_______
Social Security, Pension, Annuity, and Veteran's Benefits	_______	_______	_______	_______

Alimony, Child Support, Military Family Allotments _______ _______ _______ _______

Income from Business Self Employment, and Dependents _______ _______ _______ _______

Rent, Interest, Dividend, and Other Income _______ _______ _______ _______

Total Income __________

Please attach the following documentation:

identification/address (Driver's license, birth certificate, employment ID, social security card, or other)

income (prior year tax return, three most recent pay stubs, or other)

insurance (insurance card)

Medicaid (application made or evidence of rejection)

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (print): **Date:**

Signature:

Office Use Only

Date of Service:

Discount:

Approved Date: